Team Approach to Disclosure

DISCLOSURES/COI

• Venetia Bourrier
• I have no conflicts to disclose
  – Am a pharmacist who works in Quality, Patient Safety & Risk at CancerCare Manitoba (CCMB)
  – Have never received any speaker/consulting fees

A Patient’s Perspective

• When things go wrong, patients and families need to know what happened
• We need to know that changes have been made and will be made to prevent a similar event in the future
• We need to hear the words “I’m Sorry” from those involved in the event

Donna Davis
Co-chair, Patient Safety Canada
PATIENT SAFETY INCIDENT DISCLOSURE
• A documented and coordinated approach to disclosing patient safety incidents to clients and families, which promotes communication and supportive response, is implemented.

GUIDELINES
• Disclosure of patient safety incidents is an ongoing discussion that includes the following core elements:
  • Informing those affected that a patient safety incident has occurred and offering an apology
  • Explaining what happened and why, as facts are known
  • Discussing the immediate actions taken to care for the client and mitigate further harm
  • Reviewing recommended actions to prevent future incidents
  • Offering support to all involved

Patient Safety Incident
What do we do?
Circumstances when disclosure should take place

Case Summaries

DISCLOSURES/COI

- Benjamin A. Goldenberg MD FRCPC
- I have no conflicts to disclose
  - Am contracted physician with CCMB/WHRA; am an assistant professor within the Faculty of Health Sciences at U of M.
  - Am Co-I and Sub-I on several CCMF and CCTG funded prospective clinical trials.
  - Have never received any speaker/consulting fees
Physicians and the Disclosure Process

- Physicians have the immense privilege of being able to establish therapeutic relationships with people and families at their absolute most vulnerable
- At the same time, we encumber a significant burden and moral distress as witnesses/elements to a system that is fallible.

CCMB Critical Incident Review Process with Disclosure

- We are uniquely positioned amongst subspecialties as care/treatment we provide is marked by its complexity, risk for interactions and expectations of toxicity
- We by necessity work as partners in complex team-based care, both buffering the likelihood of an individual committing error but also potentially increasing this risk
- We are accustomed (trained, somewhat) to manage uncertainty and communicate bad news

A. Surbone et al., Journal of Clinical Oncology, Vol. 25, No. 12, April 20, 2007: pp. 1463–1467
My experience Navigating Process

1) Leave the ego and hubris behind
2) Be very deliberate, careful and transparent when collecting data
3) Inform all involved parties (and include if possible)
4) Promptly arrange disclosure meeting
5) Meet face to face, on patient’s time
6) Be very deliberate, careful and transparent when conveying error and next steps to patient and family
7) Apologize on behalf of system as an advocate for safe, just culture
8) Take ownership on follow up and pushing the process along

(THIS HAS EVEN ENHANCED THE RAPPORT AND DEPTH OF OUR THERAPEUTIC RELATIONSHIP)
FROM CCMB Review Process

- Procedure for Disclosure of a Critical Incident
  - The physician providing care should be the most appropriate person to disclose the event details of the incident to the patient and/or family. The determination of this physician will be influenced by:
    i. Setting and type of event
    ii. The individual who is most responsible for the patient’s care
    iii. Consideration of the following:
        Who is most knowledgeable about the event
        Existing relationship with patient and family
        Ability to explain future care plan
        Patient’s (or family’s if applicable) preference

CCMB Critical Incident Review Process with Disclosure

Supporting the Patient during Disclosure

The Patient Rep role
DISCLOSURES/COI

• Barbara Kitzan
• I have no conflicts to disclose
  – Am a nurse who works as a Patient Representative at CancerCare Manitoba (CCMB)
  – Have never received any speaker/consulting fees

Plan the Discussion

Plan for the initial disclosure discussion with the patient/family
• Check if the patient is aware of the incident (usually done by the physician involved and if not, contact the physician to find out when the patient will be notified).
• Make direct contact with the patient (in person/by phone) to explain the role and upcoming process.
• Plan to attend the initial disclosure.
• Important to make sure the patient is attending the appointment/meeting with a friend/family/support person.

Preparing for Disclosure

• Confirm team members for disclosure
  – QPSR/physician or delegate/patient representative

• Meet with the team prior to plan conversation
  – Critical to have a plan of what will be communicated (initial disclosure different from final disclosure)
  – Review the situation and ensure awareness of incident details
  – Location for disclosure
Preparing for disclosure cont...

• Important meeting aspects to consider
  – Location
  – Individuals present (ensure the patient has their support person)
  – Set up (comfortable setting, Kleenex, water, watch for potential intimidation)
  – An appropriate amount of time for explanation & questions

Patient Rep: Providing a “Neutral” Support to the Patient

• The Patient rep is present to support the patient
• The patient rep is not part of the executive/management or clinical team
• The patient rep often has insight on what the patient/family need from the disclosure
  • can assist the disclosure team in meeting the patient’s needs during the disclosure
  • The patient rep continues contact with the patient/family throughout the CI process and after final disclosure if needed

What our patients need from disclosure...

In my experience, patients can forgive “life-altering” events if we provide these three things
• They need to be heard
• They need a genuine heartfelt apology
• They need to know what will be done to ensure this doesn’t happen to anyone else.

Did we learn from our mistakes?